

**Patient Fees**  
**as a Metaphor for so much more**  
**in New Zealand's**  
**Primary Health Care System**

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# ABBREVIATIONS

ACC	Accident Compensation Corporation
CSC	Community Services Card
DHB	District health board
GP	General practitioner
HUHC	High Use Health Card
Ministry	Ministry of Health
MSO	Management services organisation
PSAAP	PHO Standard Agreement Protocol Group
PHC	Primary health care
PHO	Primary health organisation
SIA	Services to Improve Access
Strategy	Primary health care strategy

# EXECUTIVE SUMMARY

## ***Background***

This report presents findings from the “fees theme” of the *Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy*. It is the fourth report of the *Evaluation*, which was undertaken between 2003 and 2009 by the Health Services Research Centre, Victoria University of Wellington, and CBG Health Research Limited, Auckland. The research is funded by the Ministry of Health, the Accident Compensation Corporation and the Health Research Council of New Zealand.

The *Evaluation* is required to describe implementation of the Strategy and to identify areas where difficulties are being encountered or changes might be required. In this report, we explore a number of key issues relating to the payments made to general practitioners to support primary health care delivery, the arrangements for which have changed significantly as a result of the implementation of the *Primary Health Care Strategy*.

## **The institutional arrangements introduced under the Strategy**

The Primary Health Care Strategy (the Strategy) altered funding arrangements for primary health care (PHC), with the intent of promoting a population-health approach and of promoting the role of non-GP health professionals.

Under the Strategy, the main mechanism for delivering public funding to PHC has changed from fee-for-service to capitation, and from targeted to universal public funding. Capitated funding is delivered to primary care providers by entities introduced under the Strategy: primary health organisations (PHOs). There is no requirement to use capitation as a mechanism for distributing funding within PHOs, however, which leaves open the possibility that providers might continue to receive public funding in the more traditional form of fee-for-service.

In addition to receiving public funding, most practices charge patients a co-payment or fee. An important part of the Strategy has been increased funding to primary care, with the policy intent of reducing the fees paid by patients.

The institutional arrangements governing the setting of fees have changed as the Strategy has been implemented – including the introduction of the PHO Standard Agreement Amendment Protocol Group (PSAAP) and associated processes, and the Very Low Cost Access payments scheme.

## **GPs’ response to the Strategy: fees as a metaphor**

Despite widespread support for the objectives of the Strategy, there was also widespread criticism by GPs and professional groups about the way it was introduced. The criticisms and subsequent debate often seem to have focused on the issue of fees charged to patients. It appears that fees have become a metaphor for so much more than patient charges, but with different meanings to the government and to GPs.

To the government, fees are a metaphor for patient access; a shift to capitation accompanied by a reduction in fees is seen as symbolic of improved access and a population-health approach. To GPs, by contrast, fees represent the freedom to charge patients and are a symbol of GPs’ autonomy and status as trusted professionals.

There is a body of work in organisational theory showing the inevitability and ubiquity of metaphors in organisations. Implicit in this literature is the possibility of changing the discourse and debate, and moving towards less conflictual ways of interacting.

## **Research Process**

The analysis in this paper is drawn primarily from semi-structured interviews conducted with a range of PHC stakeholders as part of the *Evaluation*. In these interviews, stakeholders were asked a range of questions relating to the issue of “keeping, or bringing, the level of co-payments down”.

The interviews were conducted in 2006. Since they appear to reflect underlying themes, we believe that the results continue to be valid. However, some institutional arrangements relating to fees have changed in the last two years. Additional interviews, which include an assessment of the impact of such changes, were conducted in early 2009, and the results of these interviews will be incorporated in a later report.

We also report results from three relevant questions that were included in the surveys conducted as part of the *Evaluation*. These surveys were undertaken with practice managers, GPs, and practice nurses. Full details of the survey methods and response rates are included in an accompanying report, *Status and Activities of General Medical Practices* (Raymont and Cumming 2009).

## **The Level of Patient Co-Payments**

Consistent with empirical evidence, most GP survey respondents believed that fees had decreased; and most supported this as an objective. Some were positive about the level of funding they had received under the Strategy and considered it had had a beneficial impact on their practice. Others considered that, given the needs of their enrolled population as well as rising demand and rising costs, their fees had hit a “floor”. A number of interviewees noted that process of implementing the Strategy had created a level of uncertainty which meant that it would not be financially rational for them to lower their fees further.

## **Opposition to Government Control of Patient Charges**

As well as opposing any further reductions in fees (without there being additional public funding), many interviewees expressed resistance to government control or intervention in setting patient fees.

### **Concern about potential threats to viability**

Concern was expressed that the government would have insufficient information for setting fees accurately, or for reflecting variations between practices and changes over time in costs and demand.

### **Principled opposition to government intervention**

A small number of interviewees considered that the government should not interfere in the operation of market forces. (We note that, by contrast, some other interviewees volunteered a belief that it was right for the government to seek accountability for the use of public funding.)

## **Opposition to control of business and professional practice**

A desire to protect income is not the only – or even the primary – reason why GPs are opposed to government intervention. For some GPs, their ability to be a private business and to determine their own patients' fees is symbolic of their status as autonomous professionals. To these interviewees, fees are a metaphor for so much more than patient charges. Moreover, some GPs appear to view it as their professional duty to set charges at a level that patients can afford, and to pass on as much as possible of the increased funding. If this is the case, accusations that they are not doing so are likely to be “heard” by these GPs as accusations that they are not acting as responsible professionals. It also appeared that some GPs consider the arguments over funding to impugn their worth –they perceive that they are under-funded and therefore not valued or valuable.

## ***Population-Health Services and the Strategy's Funding***

A core objective of the Strategy is a desire to introduce a population-health focus by moving the funding of general practice and PHC away from a fee-for-service model towards one based on capitation. This implies a shift away from a system where patients pay the GP for each visit they make, towards one where the GP receives a per-annum sum of money which is intended as the funding for whatever care that a patient might need (including health promotion and illness prevention).

PHOs receive capitation-based funding; but there are no regulations governing how that funding is delivered to practices and how it is delivered to PHC professionals or used for providing services within practices. The *Evaluation's* interviews and survey data confirm that key decision-makers (PHC professionals) are often still practising under fee-for-service incentives without the incentives or flexibility offered by capitation funding. It is challenging to develop a population-health approach when income is (or is perceived to be) dependent on patient visits. Many interviewees wrestled with this, and with seeking to improve the health of the practice population while continuing to generate sufficient income.

## ***The Perceived Role of PHOs and DHBs in Setting Fees***

At the time the interviews were conducted, there was significant diversity between different district health boards (DHBs) and different PHOs in their approach to managing fees charged by practices. Some appeared to be “powerless”, some took a deliberately “soft” approach, and some appeared to be directly interventionist.

## ***Discussion and Policy Options***

### **Fees as a metaphor for so much more**

Our analysis suggests that, while the aims of the Strategy were largely supported by general practice, the intention to use public funding to reduce patient fees raised wider fears about government control of general practice. General practice fees appear therefore to have become a metaphor for the relationship between the state and general practice and, within that, for a process whereby the government's mistrust of a powerful professional group and that group's concern at a perceived attempt to erode its autonomy and sense of professionalism is acted out.

Stakeholders appear to be unhappy – and, perhaps, resigned – about the state of this relationship. However, organisational analysis in the metaphorical and sense-making tradition suggests that the situation could be reframed and, over time, a new relationship (and hence metaphor) shaped. There is now an opportunity to change the way in which stakeholders construct the relationship between general practice and the state.

### **Taking forward the Strategy in order to meet population-health objectives and access objectives**

As long as there continues to be a widespread fee-for-service culture in PHC, it will be difficult to develop population approaches to the provision of health care. However, when considering this, it is also important to note that many practices are using the new funding to develop new approaches to providing PHC services.

### **The role of contracts in PHC**

The incremental approach to implementing the Strategy has seen a gradual introduction of arrangements that can be viewed as a shift towards more formal contracting. However, it is important to note that in this type of context contracts will inevitably be incomplete, giving informal arrangements (including trust) a vital role in making sure that the government's outcomes are reached. Moving beyond the dysfunctional focus on fees will be vitally important to restoring trust and making sure that the sector as a whole is able to perform to its potential.

## ***Conclusion***

Our analysis of fees and funding within the Strategy is intended as a contribution to the debate about the Strategy's implementation. A vital part of advancing the core aims of the Strategy will be to change the metaphor and remove the focus on fees.

# 1 INTRODUCTION

Unlike the situation in many other OECD countries, the New Zealand government has traditionally provided only partial subsidies to support access to primary health care (PHC) services, with New Zealanders paying for much of their own care through fee-for-service user charges paid to PHC practitioners. It is widely felt that these charges have resulted in significant barriers to access to care, especially for those on lower incomes (see, for example: Health Benefits Review 1986; Ministry of Health 1999; Ministry of Health 2004; Raymont 2004). The 2002/03 New Zealand Health Survey, for example, showed that one in eight (12%) of adults needing to see a GP in the previous 12 months had not seen one, with 48.5% reporting cost as a key reason for not accessing services (Ministry of Health 2004).

The Primary Health Care Strategy (the Strategy) was introduced in 2001 in order to improve health and to reduce inequalities in health. A key set of changes brought about by the Strategy has been to increase the funding available for supporting PHC services (including general practice services) and to reduce the fees that patients pay when they use services.

The Strategy's core mechanism for delivering public funding to general practitioners (GPs) is capitation payments, which are delivered to general practices through the new organisational form of PHOs (Minister of Health 2001a). In addition, many patients continue to pay fee-for-service payments for their GP visits. The policy intention has been that these fees (co-payments) be reduced following the provision of new funding to general practice. With respect to capitation funding, the policy intention is that general practice will focus on the health of their enrolled populations and will provide a range of services designed to keep the practice population healthy. This is a vital part of the government's desire to shift from a patient focus to a population focus in health care delivery.

In this paper we explore themes emerging from an analysis of data from semi-structured interviews carried out in the New Zealand health sector from June to October 2006. Although the data was gathered in 2006, the reflections on the "fees issue" within the implementation of the Strategy are critical to the next phase of the Strategy – in particular, in determining how best to structure the relationship between the Ministry, PHOs, and general practice. A powerful theme is that "fees" represent so much more than "income" to PHC stakeholders. When asked about fees and income, many interviewees discussed issues relating to control and autonomy and to being responsible professionals. In some cases these discussions emphasised the risk that fees – because they focus attention on individual consultations – would undermine the desired population-health approach.

This is the fourth report from the *Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy*, being undertaken by the Health Services Research Centre, Victoria University of Wellington, and CBG Health Research Limited, Auckland, between 2003 and 2009. An earlier set of interviews was reported in 2005 (Cumming, Raymont, Gribben, Horsburgh, and Kent 2005). Other *Evaluation* reports cover practice nurses, general practice, PHO governance issues, and the concerns of Māori and Pacific people.

## 1.1 This Report

This fourth report presents qualitative results for the “fees theme” of the *Evaluation*. It focuses on the issue of general practice fees – and in particular, on the government’s attempts to reduce the cost of access to PHC services.

Chapter 2 sets out background information about the Strategy and describes the way in which the debate around the Strategy’s implementation has focused attention on “fees” per se. Chapter 3 outlines the methods used. Chapters 4 to 7 outline the results: Chapter 4 reports attitudes to the level of fees charged to patients; Chapter 5 reports our analysis of the reasons for opposition to government control of patient charges; Chapter 6 reports our analysis of the ways in which funding mechanisms interact with the desire of policy-makers and practitioners to provide population-health services; and Chapter 7 reports on the role of PHOs and district health boards (DHBs) in determining fees. Chapter 8 discusses these results, and Chapter 9 draws the report to a conclusion.

## **2 BACKGROUND TO NEW ZEALAND PHC AND THE STRATEGY**

### **2.1 The Institutional Arrangements Introduced under the Strategy**

PHC in New Zealand has traditionally been dominated by a model of service delivery led by GPs organised as small privately-owned businesses, with income derived from both public funding and private fees charged to patients. Under the Strategy, this basic business model of general practice remains largely unchanged but has been supplemented by new institutional arrangements affecting the funding and organisation of service delivery (Minister of Health 2001a). It was intended that the changes should incentivise changes in behaviour, leading to improved health outcomes.

The delivery structure was altered with the introduction of PHOs. These comprise groups of primary care providers, including general practices and other community health care providers. They are essentially governance organisations charged with promoting the co-ordination of services and with ensuring the development of services to improve and maintain the health of the population. The Strategy was designed to promote the role of non-medical community health care providers, and this is reflected in the way that PHOs have been directed to make decisions and co-ordinate different types of services. It is also important to note that, since the Strategy, primary and community health services have continued to be delivered outside PHOs.

Prior to the full implementation of the Strategy, the core source of public sector funding for PHC was paid to GPs as a fee-for-service payment for each patient visit. This funding was targeted to lower-income New Zealanders holding a Community Services Card (CSC) and to high users of general practice services holding a High Use Health Card (HUHC). Under the Strategy, the funding model changed from fee-for-service to capitation and from targeted to universal public funding; all New Zealanders who attend a PHO-affiliated general practice are now eligible for the new funding.

The shift to capitation funding and to universality reflected a desire for a stronger population focus in PHC. Capitation was also designed to reduce inequalities by tying PHO funding to population needs rather than to the number of services being delivered. It was, in addition, intended to encourage multidisciplinary team approaches to PHC (including an increase in the role of nursing), since it decoupled funding from GP-provided services.

There are four capitated streams of funding: first contact funding; Services to Improve Access (SIA); health promotion services; and management services. Higher capitation rates are paid for individuals from particular population groups and (in management services funding) for individuals enrolled with smaller and medium-sized PHOs. PHC providers, including GPs, also receive other sources of funding that include payments for maternity, immunisation and ACC services – and “Care Plus” payments for patients needing additional services (such as chronically ill people).

Capitation funding is delivered to individual health care professionals via DHBs, PHOs and primary care providers. There is no clear centrally-defined mechanism specified for the delivery of funding to primary care providers (which include practices and GPs). The government did not impose a requirement to use capitation as a mechanism for distributing funding; and the incentives for adopting a population-health approach are undermined to the extent that key decision-makers (PHC professionals) do not actually receive capitated funding.

Practices continue to be able to charge patients a co-payment (a “fee”) and most practices do so. Significant levels of new public funding were given to PHC providers, and the government intended that these should decrease patient co-payments. Decreased co-payments were, in turn, intended to improve health outcomes: directly, by improving access to services; and indirectly, by reinforcing the population-health approach.

Initially there was no formal contract with GPs on the setting of charges to patients. There was, however, a standard national contract agreement between a district health board (DHB) and a PHO. This agreement underpins the allocation of funding by the DHB to its PHOs; the agreement also sets out the PHC services to be provided by the PHO, along with associated tasks and management services required of the PHO. PHOs are able to provide services themselves under the agreement, or to subcontract them to others. In 2004, a process was established to negotiate and agree variations to the standard PHO agreement under the PHO Standard Agreement Protocol Group (PSAAP). This process has resulted in a system for reviewing fees and auditing the PHO-DHB agreement, and for the annual roll-out of new funding for PHC. PSAAP comprises representatives from DHBs, PHOs and the Ministry.

Funding incentives specifically designed to promote the aims of the Strategy have also been introduced. In October 2006, practices and PHOs charging very low fees became eligible for higher levels of funding under the Very Low Cost Access payments scheme. Under this scheme additional funding was provided to very-low-cost practices from July 2007; the aim was to keep children’s visits free (ie those aged under six), visits for those aged 6-17 at no more than \$10.50, and adult visits at a maximum of \$15.50 (Minister of Health 2007). The additional payment has two components: a 20% increase on the first-contact capitation payment for each practice that meets the very low fee threshold; and a 20% increase on SIA funding (where all practices meet the very-low-fees requirement *and* the funding is used to implement the Strategy – including reducing health inequalities).

The “blueprint” for the reforms introduced by the Strategy did not specify formal arrangements for governing relationships within the sector. Nor were the roles of the different organisations clearly specified. This may be consistent with good governance in complex adaptive systems, which need clear rules or principles to guide change processes rather than the imposition of too many specific plans (Sibthorpe, Glasgow and Longstaff 2003). However, at the time of the *Evaluation’s* interviews, there had been no formal definition of the roles of PHOs, DHBs and the Ministry in setting the fees charged in PHC. Since the interviews, a number of formal arrangements have been introduced to give greater clarity: these include the fees review process and the PHO performance management programme. In addition, PSAAP has agreed a fees framework that provides guidance on how fee increases will be approved.

## **2.2 GPs’ Response to the Strategy: Fees as a Metaphor**

The Strategy was welcomed in principle by health professionals’ groups, particularly since it signalled additional resources and a renewed emphasis on PHC services. There was, however, also considerable suspicion from individual GPs, voiced in the first *Evaluation* report (Cumming et al. 2005) and in the media. To some extent this suspicion reflected a historic and long-running tension between the government and GPs – and, perhaps, between different models of PHC provision (Hay 1989).

During the implementation of the Strategy this tension and suspicion has been manifest in ongoing disputes over charges to patients, apparently almost to the exclusion of everything else. An external observer of the New Zealand PHC system could be forgiven for thinking that the Strategy is concerned solely with attempts by policy-makers to reduce the fees that patients have traditionally paid when they have consulted a GP. Despite the Strategy’s focus on capitation funding and population health, the issue of patient fees seems to have taken centre stage in much of the discussion about New Zealand general practice. For example, in an article in the *New Zealand Listener*, the following observation was made:

*Some GPs have fiercely resented the government's insistence on controlling fees in the face of concerns, seeing it as an unwelcome state intrusion into the freedom of small businesses to set their own charges. They have been particularly offended by the government's readiness to portray them as greedy pilferers of the public purse whenever they complain that fees are set too low. (Boniface 2007)*

The focus on fees and the nature of the debate suggests that fees may have become a metaphor, with different meaning to the government and to GPs.

To the government, fees are a metaphor for patient access, with a shift to capitation accompanied by a reduction in fees being symbolic of improved access and a population-health approach. The government's understanding of the fees issue is illustrated by the following excerpt from the 2001 Ministerial press statement that accompanied the launch of the Strategy: "The old system was based on a fee-for-service approach. The new system emphasises needs based funding for population care." (Minister of Health 2001b)

To GPs, by contrast, fees represent the freedom to charge patients; and they are a symbol of GPs' autonomy and status as trusted professionals. This means that although GPs' arguments are superficially about fees, their suspicion of the government may be driving their responses to fees-related issues and perhaps leading them to interpret government efforts to control fees as part of a wider process of "creeping control" and managerialism.

Our interpretation of fees as a metaphor is consistent with a body of work in organisational theory. The schools of postmodernism and social constructionism have had a significant influence on organisational theory, entailing the acknowledgement of multiple accounts of reality and the recognition of the power of organisational narratives (Davidson and Peck 2006). Gareth Morgan (1997) explored the metaphorical analysis of organisations, arguing that all theories of organisations are based on implicit images or metaphors that lead people to see or understand organisations in distinctive yet partial ways. Morgan asserted that the use of different metaphors can enable us to understand the complex and paradoxical character of organisational life; and metaphors he used included organisms living in ecosystems, brains engaging in learning and self-organisation, political systems reflecting interests and conflicts and power, and psychic prisons containing constraints of one's own creation.

The concept of metaphor can guide not only analysis. It can also guide action within organisations, especially where initial diagnosis by means of metaphor is taken forward into "treatment" by means of leaders using social processes to "make sense" of an alternative reality or way of operating (Weick 1995). Thus, if fees within the New Zealand PHC system are a metaphor for lack of trust and for conflict between general practice and the state, in Weick's terms it is within the gift of policy-makers and negotiators to start to create a different sense of this relationship. As Davidson and Peck (2006; p352) note: "(sense-making) emphasises the potential for changing the way in which organisational pasts, presents and futures are constructed by organisational members."

In this report we test the hypothesis that, to GPs, fees represent the freedom to charge patients and are a symbol of GPs' autonomy and status as trusted professionals. We explore ways in which this is manifest and how this impedes the successful implementation of the Strategy.

### 3 METHOD

As part of the *Evaluation*, interviews were conducted with people in general practices, PHOs and DHBs, and with individuals involved in the management and monitoring of the the Strategy's implementation. Interviewees were selected from 20 PHOs, which were chosen to represent a range of PHOs; and those with a focus on Māori or Pacific people were deliberately over-sampled. (For a full discussion of the sampling frame and method, see Raymont and Cumming 2009.)

Within each PHO, it was intended that an average of eight interviews were undertaken. These included:

- the PHO chair
- the PHO manager
- Māori, Pacific, and general community PHO board representatives
- a GP and a nurse who were also on the PHO board
- a GP and a nurse who were not on the PHO board.

The relevant DHB primary care managers were also interviewed, as were representatives of the Ministry and of national organisations that represent PHC professionals. To ensure their anonymity, interviewees from these professional organisations are referred to in this report as national stakeholders and are not linked to a specific organisation.

On occasion, two or more individuals were interviewed together (sometimes as focus groups); but care was taken to ensure that those with potentially opposing views or interests were interviewed separately.

Each interview was conducted in an open-ended manner, with a general guide identifying high-level themes supplemented by "probes". The material relevant to this report comprised the theme "**Keeping, or bringing, the level of co-payments down**" with the following probes:

- Do you have good data on the fees that are being charged? How would you summarise the present fee situation?
- Why do fees vary and what does fee variation achieve?
- What role does the PHO have in reducing fees?
- What has been done to reduce fees?
- What hinders achieving lower fees?
- What could be done to maintain a low fees environment?
- How can funding arrangements be improved?

Interviews were not transcribed; instead, individual interviewers reported their findings thematically. In some cases the interviewers' reports combined the results from different interviewees. Thematic reports were then disseminated to the authors of this and other *Evaluation* reports, for analysing the results for particular themes.

Within the "fees" theme reported here, two of the authors reviewed the interviewers' thematic reports independently. They identified emergent themes, and then compared findings to arrive at hypotheses. The data were then reviewed again to test and (where hypotheses were found to be valid) to populate a narrative that related to each hypothesis.

The interviews were conducted in 2006. We believe that the results continue to be valid since they appear to reflect underlying themes and later research the research team members are involved with reflect similar themes. Some institutional arrangements relating to fees have changed in the last two years, in particular with the introduction of the Very Low Cost Access payments scheme and the more detailed PSAAP processes. (Additional interviews were conducted in early 2009: these include assessment of any changes in the impact of funding arrangements on the PHC operating environment and will be incorporated in a later *Evaluation* report.)

In addition to the interviews, a PHO Survey Questionnaire was sent to PHO board members and managers; and a Practice Survey Questionnaire was sent to managers, GPs and nurses within general practices. In this paper we do not draw extensively on these results; but we report results of three relevant questions relating to the distribution of income within practices and the role of PHOs in setting fees. (For details about the Practice Survey, see Raymont and Cumming (2009); for details about the PHO Survey, see Barnett , Smith and Cumming (2009).)

## 4 THE LEVEL OF PATIENT CO-PAYMENTS

To the government, a key to successful implementation of the Strategy was achieving lower patient co-payments (“fees”). Empirical evidence suggests that in the years preceding the interviews (2001 to 2005) average fees fell, but not by as much as the government hoped (Gribben and Cumming 2007). Fees generally fell in those groups for which new funding had been provided: that is, for those over six years of age who attended Access-funded practices; and (after July 2004 when new funding was made available for those aged 65 years and over) for people over 65 who attended Interim-funded practices.<sup>1</sup> The extent of the fees’ fall in Interim-funded practices was, however, less than the government had hoped.

This empirical evidence is consistent with the *Evaluation’s* interview data, which suggests that at the time of the interviews many GPs perceived they had hit a “floor” in terms of lowering fees. Many commented that they had lowered fees, and that they supported this as an objective.

*We all want the fees to go down. People are never happy with paying practice fees but it depends how they prioritise. People have commented that it is pleasing that fees have gone down and it particularly makes it easy for parents with numerous children. But we are accommodating to those who have financial hardship. (Practice nurse board member)*

*There is a willingness to work jointly with the DHB and the Ministry to achieve better outcomes for our patients. Patients will attend GPs if they do not have to pay so much. (PHO manager)*

Some interviewees were positive about the level of funding they had received.

*My income is a lot better than it was, even though I have had to reduce my fees. That has trickle-down benefits for the running of the practice overall. (GP)*

*Capitation has been a good thing and a win-win situation for both the Ministry and general practice. It has given good-quality general practices, who do not over-service patients, a financial boost. (GP)*

*Government concentration on primary care is a real plus. The emphasis is to try to keep people healthy and prevent hospitalisation. Part of that is to get people to see their nurse or GP sooner rather than later. But additional funding and the emphasis on primary care has had a significant impact on us, and will continue to do so. (PHO chair)*

However, most interviewees considered that they could not lower fees further, given funding levels, the nature of their patients, rising practice costs, and rising workloads. This view was expressed in different ways by different types of practices and GPs.

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<sup>1</sup>. Initially there were two funding formulae: Access and Interim. Access PHOs and their affiliated (“Access-funded”) practices were those whose enrolled populations were identified as having higher needs; and from July 2002, as such PHOs were established, they received capitation funding for all of their enrollees. Capitation funding was made available for Interim PHOs and their affiliated (“Interim-funded”) practices on a progressive basis: at different points in time a particular age group enrolled in Interim PHOs had capitation funding made available for it. At the time of the *Evaluation’s* interviews, the Strategy was not fully implemented and capitation funding for Interim PHO enrollees aged 25-64 was not yet available.

Some interviewees were concerned that they received insufficient funding for their high-needs high-cost patients. Their views suggest they saw the funding formula as not reflecting their population's needs.

*It would be really good to see extra funding coming through for a lot of our patients who have chronic conditions because those consultations take a lot longer. (PHO focus group)*

*The practitioners are paying for themselves basically by having small income, work long hours. So I see it as ... not a long-term viable [approach]. I think the other thing too is zero co-payments are based on patients, and our level of need in our community is well above what we get decile rated. (PHO focus group)*

*The basic Access funding needs to be revised ... the actual calculation is inadequate because we've got a system that addresses that stuff but the multiple just isn't enough and it needs to be increased by 50% for lower socio-economic groups because part of what is happening is the success of the Strategy proves to be their downfall because we're trying to provide free access – [which] is what primary care is about – by reducing the barriers. The more we reduce the barriers, [the] more patients we get within insufficient funding. (PHO focus group)*

In the time since these interviews were conducted, the need to reconsider the funding formula for PHOs has been recognised nationally. A review has been underway within the Ministry, exploring issues such as how the formula might be adjusted to take account of ethnicity and deprivation. The specific challenges faced by PHOs that have a large percentage of high-needs enrollees (as shown in the interviewees' comments above) were recognised when the Very Low Cost Access payments scheme was introduced.

Other interviewees suggested that it would not be financially rational for them to lower their fees further. They expressed their concerns in the language of business planning, using terms such as “risk analysis” (PHO manager), “business adjustments” (PHO focus group), “viability” (PHO manager), and “model(ling) cash flow” (GP). Some of these interviewees also noted that they were not prepared to lower fees, given the uncertainty of the current environment, and that they were reluctant to put in place changes now that might be hard to reverse in the future. They attributed a large part of the uncertainty they felt to the manner in which the Strategy had been implemented.

It is, indeed, important to distinguish underlying support for the objectives of the Strategy (and, sometimes, for the principle of capitation) from criticisms of its implementation. The process was variously described as “a mess” (PHO chair) and a “dog's breakfast” (GP); and this was sometimes explicitly linked to resistance to lowering fees.

*The roll-out has been piecemeal in the extreme, making it very difficult for practices to model future cash flow – and they are understandably being prudent. (GP)*

## 5 OPPOSITION TO GOVERNMENT CONTROL OF PATIENT CHARGES

As well as opposing any further reductions in fees (without there being additional public funding), many interviewees expressed resistance to government control of, or intervention in the setting of, patient fees. We identified three (not mutually exclusive) themes here: first, concerns that the government would not be able to set fees at a level consistent with a practice's financial viability; second, opposition to public intervention in a private business; third, opposition to what is perceived to be an attempt to control professional practice.

### 5.1 Concern about Potential Threats to Viability

Most GP and PHO interviewees expressed concern that the government was likely to set fees at a level that did not accurately reflect funding and costs. They believed that the government has insufficient information about the differences between practices to allow for a reasonable variation in practice funding. The dimensions of that variation include location, size, consultation type and time, overheads, and the nature of the patients.

*The variation in fees is about different practices with different overheads serving different communities; different consultation types for different people and problems. (PHO focus group)*

*Fee variation can be helpful because practices run very differently – for example [there's] a very high-charging general practice in the city, the highest in the country – but the GP specialises in homeopathy with consultations lasting 45 minutes, so on a time basis it's one of the cheapest in the country. (PHO manager)*

GP were also concerned that the government would not allow fees to change over time to reflect cost increases. They were particularly concerned about their vulnerability in the face of cost increases outside their control, such as rising staff costs. Sometimes this belief was expressed as if it was based on past experience. (For example: one interviewee, a GP, stated “Will find that funding will fall behind, like maternity”; and an interviewee in a PHO focus group referred to a 16-year delay in increasing subsidy payments prior to the 1990s.) At other times this concern was expressed as a general mistrust of the government.

*GPs are deeply suspicious of any step backwards in fees because it will be met with some fine print that says they are [done over] in five years. (GP)*

Connected to this was concern about the impact that lower fees would have on demand, and whether the practice had sufficient space or staff to meet such demand. As discussed later in this paper, this concern in part reflects the ongoing focus on fee-for-service and individual consultations. However, it is also a rational concern if providers are up against capacity constraints (both physical and workforce).

*We've had to expand our building to accommodate the extra load – the extra volume of people that we're seeing – so we're paying twice the rent but not generating twice the income. (Practice nurse)*

*The more we reduce the barriers, the more patients we get within insufficient funding. The practitioners are paying for themselves basically by having small income, work long hours so I see it as ... not long-term viable. (PHO focus group)*

The impression of rising demand is borne out by empirical evidence which shows that in some population groups, and for some Access-funded practices, the number of consultations increased by up to 20% in the four years preceding the *Evaluation's* interviews (Gribben and Cumming 2007).

## **5.2 Principled Opposition to Government Intervention**

A number of interviewees emphasised that general practices were small businesses, which is consistent with the business model that has historically dominated general practice in New Zealand. A small number of interviewees appeared to have a principled belief that the government should have no involvement in private business, which seemingly reflected a belief in the importance and validity of market forces.

*Fee variation encourages robust competition between practices and remains true to current Commerce Commission rules. (GP board member)*

*The autonomy of the practices is paramount. They consider it is an open market and (so) why should fees be restricted? Why not allow supply and demand to take effect? (PHO manager)*

Conversely, a small number of interviewees recognised and agreed with PHC providers being explicitly accountable for their use of public funding.

*The government quite rightly wants to see some benefit accruing from its injection of millions of dollars in assisting reducing the fee burden of [those] wanting to access primary care. (PHO chair)*

*Personally I consider the DHB proposals (about fees review) are quite reasonable. Yes we are a private business, but also we are a private business subsidised to a large extent by the government. It's public money so it's not unreasonable for there to be some kind of transparent mechanism whereby those fees can be reviewed to see if they are fair. And as long as it's an independent process, I don't personally have any problems with it. (GP)*

*I understand the problems that the government has. I fully understand that if they pay a subsidy it must be passed on to the patient – and I can be transparent because I have a group of patients who are not subsidised at all. "There," I can say, "this is my fee".(GP)*

### 5.3 Opposition to Control of Business and Professional Practice

Most GP and PHO interviewees articulated views about the GPs' ability to set fees as an issue relating to control. When they discussed fees, there was frequent use of and emphasis on the words "freedom", "autonomy", and "control". It is clear that there is a widespread and deeply held belief by GPs and PHC sector managers that the attempt by the government to influence how the subsidy is used, and to influence the levels of fees charged to patients, is an attempt to control the GPs' business and their practice.

*It's the PHO's job to make sure that the fees are reasonable but as the GP rep I don't believe that it's the board's job to decide what a private business should charge their clients. (GP board member)*

*Our docs will pass on the \$27 to the patients, but they will resist having their fees controlled. GPs are concerned; they do not want government controlling their business. They are independent businesses. (PHO focus group)*

*Capitation is a good thing – it has given good-quality general practices, who do not over-service patients, a financial boost. For the patient, it has also been [a] good – patients have enjoyed better access with all the initiatives (like Care Plus). The issue is that government should not seek control of fees. (GP)*

*I have a clear view of fees and it goes right back to 1938: the government of the day accepted that GPs would be private businessmen and they would charge fees ... and we still have GPs who are private businessmen. Some governments do not like that [and] the GP groups say fine – nationalise us, buy us out. (PHO manager)*

*There is no way at the end of the day that GPs will allow the government to control their private business; they are paid a subsidy, not a salary. (PHO chair)*

*To them, it is not just control of fees, it is also control of GP business. Some practices will decline [the funding] on the basis of a perceived takeover of general practice. (DHB manager)*

Opposition to the control of fees might reflect, in part, insecurity about personal income. Some interviewees volunteered answers consistent with there being a structural conflict in the business model – between GPs' personal income, which depended on their practice income, and the government's agenda to lower the fees charged to patients. However, the narrative used by the interviewees suggests that a desire to protect income is not the only – or even the primary – reason why GPs are opposed to government intervention. Most stated a commitment to keeping fees as low as possible. Indeed, a number of interviewees obviously wrestled with having to charge patients at all: they expressed some ambiguity about charging patients and viewed it as a necessary evil. One GP referred directly to GPs' "social conscience" as a restraint on GPs increasing charges to patients.

This report's analysis suggests something more subtle than income protection is at work. For some GPs, their ability to be a private business and to determine their own patients' fees is symbolic of their status as autonomous professionals; it is this they wish to protect. These GPs were concerned not only about control of their business, but also of their practice. To these GPs, fees are a metaphor for so much more than patient charges.

One of the interesting themes emerging from the interviews is that some GPs view the charging of affordable fees to be their duty, as responsible professionals and as patients' agents. This is evident when they describe knowing how much "their" patients (or even "their" communities) can afford to pay – and when they describe how they take care not to overcharge, and to discount fees appropriately for patients who cannot afford to pay.

*It's quite obvious who are able to pay and who are not. Our doctors are really good in that respect – they tend to charge people less or let them off. (PHO manager)*

*Trying to get all the fees to the same level is pointless. What happens is that GPs have always responded to their communities, and fees reflect the community. Mostly you are charging what the community can afford. (GP board member)*

*The subsidy is passed on and the fees are lower than most – traditionally we charge lower fees than other practices and it's probably just because of our population base – they cannot afford (more). (GP, PHO chair)*

As suggested by the last quote, interviewees also expressed their responsibility to patients in terms of having a commitment to passing the funding on to patients. Almost all considered that at least part of the increased funding was being passed on to patients, in their practice and by most other GPs. In this context it is notable that interviewees used terms such as "good" (PHO focus group) and "responsible" (two GPs; one was also a PHO chair) to describe the doctors who were passing on subsidies. This belief – that as patients' agents they are already acting responsibly with respect to charges – is likely to be a filter through which the interviewees mediate any accusations that they are "greedy" and are pocketing extra income. It is also likely to be driving their expressions of indignation at accusations which they perceive as meaning that they are not to be trusted to charge *their* patients and *their* communities an affordable fee. In these expressions, adequate payment is a metaphor for being valued; and the ability to charge fees autonomously is a metaphor for being a trusted agent.

It is notable that some individual GPs consider other practices or even other GPs within their own practice are not keeping fees down and are not necessarily passing on the subsidy. Some of their grievance relates to being "tarnished" by the "naughty" ones, and not "trusted".

*There are always going to be greedy doctors but they are in the minority. We do a disservice to focus on these and not on the majority who are passionate about good quality health care and who do pass on all the subsidies to a greater or lesser extent. (PHO chair)*

Indignation is also evident in some interviewees' expressions of grievance about being undervalued (by the government and by their patients) when they charge fees, as if they are using the level of their fees as an indication of their worth.

*The other thing is about GPs increasing their fees every year. The key thing to remember is that GPs already felt that their fees were too low for the service that they were providing. GPs compare themselves to hospital specialists and do not consider themselves to be less worthy. ... I think we are undervalued by the health system and I think that that is what the fee thing is all about. (GP)*

*I would love to spend my medical life not charging anybody. It would change things completely – [I] would have much more enjoyment and job satisfaction and then I would negotiate my salary with my employer. I would have no trouble with that. Patients forget that this is a business, and when they come back for the same problem there is often a lot of conflict. [They] say “Isn’t this the same problem? It’s going to be free, isn’t it?” (GP board member)*

*Patients should pay something for the care that they receive because then they are valuing the service that is being offered to them. (Practice nurse)*

This use of the level of fees as an indication of professional worth points again to the importance of fees as a metaphor for so much more than just the cost of a consultation with a GP. The first quotation above suggests that fees and associated income are tied up with professional worth, as measured in comparison with that of hospital specialists who traditionally have been viewed in many health systems as being in some way “superior” to their general practice colleagues.

It is notable that not all of the interviewees considered it is the GP’s role to be the patients’ agent with respect to setting fees. Some explicitly considered there to be a market for medical services, with patients able to choose which doctor to visit on the basis of fees and other characteristics (such as the ability to see a GP quickly). These GPs consider patient choice to be paramount. DHB interviewees also suggested that there are different “types” of GPs, with GPs selecting into specific areas depending on their preferences and with some choosing to try to attract patients who can pay higher fees in return for “boutique” services.

*Fees will vary with costs. This is a supply-side focus – not a demand focus – but presumably in a market this will be reflected in who wants to go to which practice. (Board member)*

*I believe that people are smart enough to see how much Joe Bloggs charges down the road and what service they get for that. I think there should be transparency and that people should know what the fees are – people should be able to make choices about what they want and what they are prepared to pay for. I have a clientele that have chosen me because that is the practice style they want. (GP)*

*(Fee variations are due) totally to quality of service. (GP)*

*If some are reaping a windfall, I would be hard pressed to tell. Maybe some have higher overheads or a higher quality of service ... one PHO with high fees has increased its register, one with low fees has lost numbers. You have to take into consideration the quality aspect and the ability to get in to see a GP on the day that you want. (PHO manager)*

## 6 POPULATION-HEALTH SERVICES AND THE STRATEGY'S FUNDING

The Strategy includes as a core objective a desire to introduce a population-health focus by moving the funding of general practice and PHC away from a fee-for-service model towards one based on capitation funding. This implies a shift away from a system where patients pay the GP for each visit they make, towards one where the practitioner receives a sum of money per annum which is intended as the funding for whatever care that a patient might need, including health promotion and illness prevention.

PHOs receive capitation-based funding; but there are no regulations governing how that funding is delivered to practices and, within practices, how it is delivered to health care professionals or used for providing services. This means that key decision-makers (PHC professionals) may still be practising under fee-for-service incentives. If this is the case, not only is their decision-making deprived of the incentives and flexibility offered by capitation funding; these decisions are being made within what is arguably the antithesis of a population-based approach.

That decision-makers *are* still practising under fee-for-service incentives is borne out by statements made by interviewees and by results from the *Evaluation's* Practice Survey Questionnaire.

The Practice Survey Questionnaire data shown in Tables 6.1 and 6.2 suggest that a substantial number of GPs are still reimbursed according to their number of consultations. Table 6.1 presents data for GPs who are not owners or partners, and shows that about a third of practices reimburse, in part, these GPs by tying payment to the number of patients they have seen. Table 6.2 presents results for reimbursement of practice owners or partners, and shows that 21% of the practices that responded to this question reimbursed this type of GP, in part, according to patients seen. (There are a high number of non-responses to this question.)

**Table 6.1: Method of Remuneration for GPs who do Not Share in a Practice's Profits**

Remuneration options*	N	As % of total
Fee per patient	65	24%
Fee per session	54	20%
Salary	59	21%
Fee per session & salary	9	3%
Fee per patient & salary	5	2%
Fee per patient & fee per session	16	6%
Fee per patient & fee per session & salary	1	0%
No response	67	24%
<b>TOTAL</b>	<b>276</b>	<b>100%</b>
<b>SUM OF THOSE RECEIVING SOME PART OF THEIR REIMBURSEMENT:</b>		
<b>according to fee per patient</b>	<b>87</b>	<b>32%</b>
<b>as fee per session</b>	<b>80</b>	<b>29%</b>
<b>as salary</b>	<b>74</b>	<b>27%</b>

Note: \*Survey respondents were able to tick more than one option.

Source: Data from Practice Survey Questionnaire (Q21: For regular daytime work, which payment options are used for GPs who do not share in profits?)

**Table 6.2: Method of Remuneration for GPs who Share in Practice Income<sup>#</sup>**

<b>Remuneration options*</b>	<b>N</b>	<b>As % of total</b>
Personal list size	16	6%
Fee per patient	39	14%
Fee per session	26	9%
Fee per session & fee per patient	9	3%
Personal list size & fee per patient	5	2%
Personal list size & fee per session	0	
Personal list size & fee per session & fee per patient	5	2%
No response	176	64%
<b>TOTAL</b>	<b>276</b>	<b>100%</b>
<b>SUM OF THOSE RECEIVING SOME PART OF THEIR REIMBURSEMENT:</b>		
<b>according to personal list size</b>	<b>26</b>	<b>9%</b>
<b>as fee per session</b>	<b>40</b>	<b>14%</b>
<b>as fee per patient</b>	<b>58</b>	<b>21%</b>

Note: # Owners and partners

\*Survey respondents were able to tick more than one option.

Source: Data from Practice Survey Questionnaire (Q22: For regular daytime work, which payment options are used for GPs who share practice income after expenses?)

The results shown in Tables 6.1 and 6.2 confirm views presented in the interviews. One DHB interviewee explicitly stated that funding was not distributed according to the size of the enrolled population.

*Much of the practice income is still dependent on GPs seeing patients, a major limitation when you are trying to drive lower fees and a multidisciplinary team approach. (DHB manager)*

Several interviewees commented that practices and individual GPs continue to model income and costs according to individual consultations – again the inference is that funding may still be being distributed according to patient visits rather than according to number of enrolled patients. One PHO interviewee, for example, noted that the “business environment” continues to revolve around GPs seeing patients in order to maintain their personal income (which is taken from the profits of the practice).

*Remove the fear of not seeing the patient yourself and loss of personal income that is incurred and what that means in terms of profit, your business, your income. (PHO manager)*

And a GP interviewee discussed compensating for lower fees by seeing a higher volume of patients.

*[With regard to income] we compensate by volume. I see fifty-odd patients per day and [for] ten to eleven hours per day. That is my normal working day. Most people would see twenty five – so I just see a lot of people. (GP, PHO chair)*

The interview responses also indicate that, for many GPs and practice nurses in 2006, there was still a widespread culture based on “payment for a visit” regardless of how funding was actually distributed. The idea of there being a capitated amount of funding allocated to a practice to support a person’s health promotion and care for a fixed period of time was rarely articulated in relation to questions about fees. The language was largely concerned with “fee per visit” and not “capitation payments”. This points to an underlying persistence in believing that general practice does and should continue to operate on a fee-for-service basis where each consultation has its own price, rather than there being any significant shift towards a capitation approach where practices receive a fixed sum per annum to represent the cost of care for an individual patient. In other words, it appeared in many of our interviews that the shift to capitation funding is being viewed through a fee-for-service lens: the funding is evaluated in terms of what it means for length and number of consultations, its relationship with user fees, and ultimately the costs and income associated with running a general practice. Moreover, the funding is often viewed as a subsidy on fees rather than as a capitation payment per se.

*An element of fees will always be determined by perception of what people in a particular locale can afford [but] the expense structures of practices vary considerably and the number of hours worked and the expectation of income also vary. Remember the length-of-consultation variation is bigger than the fee variation. (GP)*

*I don’t think you’d want to lower it any lower at this stage because you can work out what the average consultation is costing based on how often you see the patient or how many times – we’re at a level where you wouldn’t want to reduce or lower. The fees would be going too low for consultation. (GP)*

*By making GP visits cheaper people will visit more, which is probably a good thing. But by people visiting more, it reduces the effective subsidy. (GP)*

A number of interviewees, including national stakeholders and DHB and PHO managers, recognised this effect. They were aware that introducing a population-health focus is difficult when practitioners have a “fee-for-service” attitude and see capitation payments as a means of affording lower fees for some people.

*Fee for service - now it’s fee for contact. The driver to keep people well is in place but many practices have yet to grasp that it’s in your interest to focus on how to keep people well. It’s that business mindset [of] fee-for-service that hinders lower co-payments. We are hearing that some are charging the co-payment for the least little thing – a BP check for instance. (DHB manager)*

*There is this notion that capitation is simply a way of reducing the fee-for-service for some people. That’s how 95% of them think: the visit is the unit of currency. That makes it hard to reduce fees. We need to move away from payment for visit and get practices to change the way that they work. See the guaranteed income and understand that they will get money for good service, [for] providing better access, quality of care and health outcomes. (DHB manager)*

*Focus on the GP charges constrains thinking about how to re-model general practice so that nursing roles can be larger. If [we] focus on GP fees, then any business that wants to make sure it is stable will think about charging for ancillary services, but we don't want that. (PHO manager)*

*I think it needs a whole change of philosophy that practices probably haven't grasped – the fact that population funding is here, but they still see doctor funding. (PHO focus group)*

The challenge of developing a population-health approach using capitation funding, yet at the same time charging fees based on individual patient consultations, should not be underestimated. It is clear that some GPs consider that the viability of their practice, as a business, depends on being able to charge fees to patients. This reflects their perception that public funding is uncertain and too low (which is illustrated in the first three of the following quotations). Yet, as illustrated in the fourth quotation, it is also clear that practices wrestle with a genuine dilemma: between their desire on the one hand to deliver comprehensive and holistic care for their practice population, and on the other hand their ongoing and understandable preoccupation with securing sufficient fee income to run the business.

*To me it's very simple in terms of general practice income. There's only two sources of money – the government pays or the patient pays – and that's the only part of the equation. If you want the patient to pay less, the government has to pay more. That's it, pure and simple. (PHO focus group)*

*There is not an unlimited pot of money. We recognise that lower fees will increase visits, effectively lowering the subsidy. Therefore, to keep fees down, we recognise this and compensate accordingly. If not compensated by the funding arrangement, GPs will make some arrangements to recoup that shortfall through the patient. (GP)*

*Capitation does recognise that you have a responsibility to an enrolled patient. If you do that, you have to recognise the balancing act between those who need more and those who need less care. So the concept of the "average visit" does not make much sense, and will often depend on the area in which the doctor is practising. I don't think there is enough understanding of what that can mean to the viability of a practice. (PHO chair)*

*I will frequently have people turn up with four or five problems and I will attempt to cover them all during that consult. I often run to 25 minutes – I would rather get it all sorted out now rather than say come back in a couple of weeks [because] they never come back, they never follow up. In some practices it is one problem, in and out, no communication except for the appointment. Now I charge patients more for an extended consult ... and there is often an extra unpaid 15 minutes to write a referral letter. I sometimes wish we were lawyers who charge by the minutes spent on each case: if GPs were paid by the hour for staff training, [personal courses], court appearances ... if there was a way for GPs to be paid for the things that people do not see ... That was the intent of capitation but I do not think it was ever agreed that the amount being offered was sufficient. I would love it if there was a fee for longer consultations because that happens all the time. (GP)*

One manifestation of this dilemma was a perception that population-health services should be funded through specially tagged funds such as Care Plus and Services to Improve Access (SIA) rather than through the general capitation funding. There was one instance when an interviewee reported the use of general funds for population-health services; but, as implied in the following quotation, this was not the norm and was referred to a "cross-subsidy" rather than as a core use of the funding:

*Fees are important but it's just as important to try and get (particularly) middle-aged males to be checked. I know that at least two or three practices are subsidising men's clinics, for example. So there's a little bit of cross-subsidy within the practice, but not much. But additional funding and the emphasis on primary health care has had a significant impact on us, and will continue to do so. (GP board member)*

*We have been able to reduce the barrier to individuals from SIA funds – but only individuals, you can't touch everyone. Outreach nurses can arrange for fees to be paid from SIA funds. (PHO manager)*

This was echoed by a national stakeholder.

*Perhaps we would have been better to put this resource into SIA funding, for it is SIA that has given PHOs the flexibility to do different things. (National stakeholder)*

One of the factors leading to this apparent lack of population focus by general practice when receiving additional PHC funding has been the fees debate itself. National stakeholders were clear about their regret at the on-going focus on practice fees within the Strategy's implementation and about the need to move forward and concentrate on other aspects of the Strategy. This tension was acknowledged, with regret, by one:

*It has not been productive to have so much focus on fees – this has detracted from examining issues of access and health improvement. The way we negotiated with general practice means that we have not really moved beyond a fee-for-service approach. (National stakeholder)*

In a similar vein, another stakeholder acknowledged that the fees issue had become a central point of contest and debate, and suggested that fees had become more significant than ever in the discussions about PHC development.

*The focus by the government on fees has led to GPs being more focused on fees than ever before. (National stakeholder)*

Other stakeholders suggested that the focus on fees, and in particular the annual debate and controversy about the level and method of rolling out additional capitation funding had, in itself, taken time and attention away from the population-health work and wider PHC development activity that is intended within the Strategy.

*The downside of the fees discussion is that it's preoccupied a lot of people's time and energy and has meant that time and energy hasn't been devoted to thinking about service delivery and doing things differently and about how performance can be improved. (National stakeholder)*

These expressions of regret in relation to the fee debate's ability to detract from (or even substitute for) work focused on developing population health in PHC settings bear witness once again to an inherent tension within the New Zealand primary health system: implementation of a strong policy intention to improve population health has taken place within a system which still has as its bedrock a funding approach that is based on individual patient fees and set by practitioners who are, and think as, independent business people.

## 7 THE PERCEIVED ROLE OF PHOS AND DHBS IN SETTING FEES

Data from the *Evaluation's* interviews showed confusion over the roles of PHOs, DHBs and the Ministry. As we noted in Chapter 2, these roles have most likely been clarified by changes introduced since the interviews were conducted. We have, however, identified themes that are likely to continue to be relevant – in particular the diversity of approach between different PHOs and different DHBs, and a widespread perception among PHOs that they needed to build effective informal relationships in order to achieve influence.

Some PHOs considered that they had no power to directly influence or dictate fees charged to patients. They considered that they could achieve influence over fees only through persuasion, and by demonstrating they were on the same “side” as health care providers.

*We cannot come in with a big stick on this one. You can cajole and influence to a certain degree but you are always on the back foot. (PHO chair)*

*We are not a provider of health care. We are a facilitator of subsidy being passed on from the Ministry to the DHB, to the PHO, to the management services organisation, to the practice. We are one little step along the way. It is very complicated and people underestimate the complexity. (PHO chair)*

*It's the PHO's job to make sure that the fees are reasonable but as the GP rep I don't believe that it's the board's job to decide what a private business should charge its clients [and] the PHO has not been involved so far. When a medical centre changes its fees, they send a letter to the PHO board and we have been told we have to wait for a response from the DHB to say that's OK, but generally they[the DHB] just pass it on. (GP, PHO board member)*

In one large PHO, the chief executive explained that the PHO has to balance the need to maintain good working relationships with its practices, the requirement to ensure public accountability for fee levels and use of new resources, and the pragmatic fact of needing to be able to drive through other changes as part of the Strategy's implementation.

*The PHO has worked with practices – we try to be fair. Wellington does not seem to understand that when you are trying to lead a large number of practices you can't move too far away from them or you will lack credibility and can't lead them anywhere! So we have supported them and stood by them when they have been reasonable. With the 18-24 year olds funding, we had five practices that had not reduced by the prescribed amount, but the actual fees were below the average. The Ministry rejected a 50 cent gap, so we supported them and refused to take the money. Then the practices see that we are fair and reasonable and will support them in fair and reasonable issues. That makes it easier to make progress on other things. (PHO manager)*

It was apparent that there was variation between the PHOs in their approach to fees, and in the extent to which the issue posed any difficulties. In contrast to the views expressed above, some PHOs considered that they could directly influence fee setting behaviour in practices.

*We have our own internal process for practices that want to put their fees up – to show the whys and wherefores justifying the increase and we guide them accordingly. (PHO manager)*

*The current situation is that the members are invited to submit their fee structures to us after due consideration of the financial performance of their teams. The PHO board approves those fee structures and the intent is that we advise the DHB of those current fee structures by age groups and categories. (PHO manager)*

This variety was also apparent in responses to the PHO Survey question that addressed this issue. Some PHOs considered they had no role in decisions relating to practice fees, a small number considered that they determined fees, and most considered that they discussed or encouraged practices with respect to their behaviour in this area (see Table 7.1).

**Table 7.1: PHO Involvement in Fee Setting**

<b>PHO's role in setting practice fees</b>	<b>N</b>
No role	10
Discusses fee issues with practices	23
Encourages conformity with policy	7
Determines fees	4

Source: Data from PHO Survey Questionnaire  
(Q24: Does the PHO have a role in setting practice fees?)

It was not possible to identify a systematic typology of PHOs that links their role and influence to their characteristics. Nonetheless, and as would be expected, it seems that for smaller PHOs in areas of high need it has been easier to develop low fee access, probably because there was a history of patients having subsidised access to general practice (through the CSC and special funding arrangements). Where local primary care providers operated as community-governed organisations, the model of GP funding and employment is typically different from the independent business model norm – as evidenced by some PHO comments.

*[It] has always been a free clinic, so PHO development has made little or no difference to co-payments, with the exception of out-of-area casuals. We see ourselves as by community for community – it just so happens that the community is predominantly Māori. (PHO focus group)*

*Our PHO has reduced fees and the PHO sets the limit on fees. If somebody wishes to join our PHO the fee is capped at \$15. We have capped our fees accordingly to make it more affordable to our client group, our enrolled population. (PHO manager)*

Details on the role of DHBs in implementing the Strategy, and on how such a role would relate to that of PHOs, were not included in the original Strategy – even though DHBs were in their infancy when the Strategy was launched. The working-out of roles and responsibilities has been largely left to the local level; and, not surprisingly, there is a diverse picture when different stakeholders from across the country are asked to explain how the different actors play their part in relation to seeking to reduce general practice fees and to develop an alternative model of funding for PHC.

It is apparent from interview data that, in many areas of Strategy implementation, the Ministry was acting as the main agency seeking to bring about change within PHOs and general practice – for example in being the approving body for applications for SIA funding. It is also apparent that by 2006 the DHBs' role with respect to primary care was not clear, and that DHBs often lacked information vital to monitoring the fees environment. In some cases, DHBs appeared to feel impotent in the face of the fee-subsidy issue.

*We need to see the payments and see what is coming off at the practice level. We don't know how practice charges move, over time. (DHB manager)*

*There has been a tendency for practices to increase their fees without telling the PHO. We are the last to find out, because our contract is with the PHO. (DHB manager)*

*The situation could be better. There is information which DHBs need from PHOs [but] cannot obtain. They do not want to give fee structures to the DHB because GPs think the DHB will cap fees. This is not the case – we have reached agreement for the role (of fees reviews) but I think we as a DHB could have done better in the negotiations. We have not got fees by practice name and have not got a really strong fee-review process. The DHB cannot analyse the data because it is not being given the data to analyse. It is a difficult situation. (DHB manager)*

These comments bear witness to an apparent confusion over the respective roles of PHOs and DHBs where the Strategy is concerned. Both bodies have a population-health responsibility, both have governing bodies that include community and provider representation, both express a clear objective in relation to improving access to lower cost primary care – and yet the lines of accountability and performance management of the allocation and use of new funding are not always clear.

It was also evident that, as was the case with PHOs, the procedures adopted within different DHB areas varied in relation to how general practice fee schedules were reported and regulated.

*We have very current and up-to-date data on the present fee situation in the PHO. The last fee structure for the PHO was forwarded to the DHB at the end of March. (PHO manager)*

*The DHB has no good data on the co-payments charged at the practice level with respect to the services delivered. Rather they have a copy of the fee schedule for each PHO, which is updated in the event of a fee change. We have non-identifiable information, we are told what they propose to charge, but we don't know what is being charged in relation to the service received and to whom the services are being delivered. (DHB manager)*

This suggests that it is not possible to describe a “typical PHO” or a “typical DHB” in respect of how the fees issue is being addressed locally with providers.

The picture is further complicated by the diverse nature, size and management arrangements of PHOs – some of which are community-governed primary care providers, while at the other extreme others are large networks of general practices supported by a management services organisation (MSO) that had its roots as a GP-owned independent practice association. While this diversity can be regarded as healthy and appropriate to the nature of New Zealand’s varied and dispersed communities, it seems from this current research that greater clarity about respective organisational roles would be helpful as the Strategy is moving to the next stage. Hence it is hardly surprising to find that DHBs as well as PHOs face varying challenges as they oversee the Strategy’s implementation, with some DHBs feeling closer to and more involved in PHO development than others. As it stands, the “fees as metaphor” issue appears to be not only a metaphor for the often fraught relationship between general practice and the state, but also for the somewhat loosely defined roles and responsibilities of the major organisational players in the health system, at least in respect of the Strategy’s implementation.

## 8 DISCUSSION AND POLICY OPTIONS

### 8.1 Fees as a Metaphor for so much more

Funding and the way it is delivered has become a central issue in the Strategy and its implementation. To the government, changing the way that funding was allocated (introducing universality and capitation payments) was a key part of implementing a population-health approach. Moreover, reducing the fees charged to patients was considered central to improving access to PHC. For general practice, however, changing the way that funding was allocated represented a challenge to cherished professional autonomy and the long-standing business model of general practice. While the aims of the Strategy were largely supported by general practice, the intention to use public funding to reduce patient fees raised wider fears about state control of general practice and threatened GPs' perception of the consumer-doctor relationship as represented by the payment of a direct fee.

General practice fees in New Zealand appear therefore to have become a metaphor for the relationship between the state and general practice and – within that – for a process by which mistrust by the government of a powerful professional group, and that professional group's concern at a perceived attempt to erode its autonomy and sense of professionalism, is acted out. This relationship appears to be complicated by the presence of “partial contracts” between the state and general practice in which funding is allocated in order to try to achieve specific policy aims, but without a clearly defined contract with the provider about what is to be delivered in return for that funding. Instead the contract is held with the PHO as an agent of practices and other providers – even though PHOs have limited scope of influence over what happens within practices operating as independent businesses.

In this final chapter we explore how, when general practice fees have become a metaphor for so much else within the New Zealand primary health system, the relationship between the state and general practice could be further developed. Issues are explored within two themes: first, how relationships between the major players in the system might be reframed; and, second, how (given our findings about the strength of the fees metaphor) the Strategy might be taken forward in order to meet both population health *and* access objectives.

### 8.2 Reframing Relationships

The analysis in this report demonstrates the fundamentally conflicted relationship between general practice and the state in New Zealand, as played out within the process of negotiating and implementing reforms to the funding of general practice. Stakeholders appear to be unhappy – and, perhaps, resigned – about the state of this relationship. However, organisational analysis in the metaphorical and sense-making tradition suggests that the situation could be reframed and, over time, a new relationship (and hence metaphor) shaped.

Literature on sense-making within organisations would suggest that there is an opportunity to change the way in which stakeholders construct the pasts, presents and futures of the relationship between general practice and the state. This requires those who have responsibility for framing the relationship to “create a sense” of being able to learn from previous experience, to commit to trying to make it different in the future, to “tell the story” of opportunity and new beginnings to those surrounding the relationship, and to work to ensure that “cues” give support to the wider intention of a changed and more productive relationship. Cues in this context could include: how meetings are arranged and communicated; who attends and facilitates meetings; the location of meetings; the tone and style of meetings; the development of new opportunities for joint working beyond the contract-negotiation process initiated by both parties; and the use of inclusive language in papers and reports.

In the relatively permissive and devolved policy context within which the Strategy has been implemented in New Zealand, it appears that the Ministry, DHBs and PHOs have tended to focus on working with those providers who are keen to change in the direction preferred by the architects of the Strategy. What is less clear is how these bodies have sought to engage with providers who remain sceptical about the Strategy. In other words, there does not seem to have been an arena in which areas of critical difference between different PHC stakeholder groups could be brought to the surface, explored, debated, and eventually resolved. This research suggests that in the absence of other mechanisms or fora, the process of negotiating changes to general practice funding and fees became the de facto “arena” for this difficult work. It is therefore unsurprising that the fees issue has become a metaphor for so much else, and is so laden with angst and frustration.

This analysis of fieldwork data about the issue of PHC funding and fees points to a need to bring to the surface the issues at the heart of the relationship between general practice and the state, along with eliciting a commitment from both sides to seek to reframe the relationship and how they wish to work together in future. Only if this takes place will the PHC community be able to develop new ways of working that will deliver the all-important Strategy objectives of greater team-working, new models of care for people with long-term conditions, and better co-ordinated care. Evidence from the literature (see, for example: Iles and Sutherland 2001; Pettigrew, Ferlie and McKee 1992) suggests this will be a difficult process that is likely to require skilled and independent facilitation along with acknowledgements, concessions, and compromises from each party. Critical to the process will be the establishment of areas of agreement, the identification of areas of profound unhappiness, and the working-through of some ways in which the state and general practice can mutually reframe and “make sense of” a more creative and constructive relationship.

The research reported in this paper suggests that without effort of this nature at a national level, DHBs and PHOs will continue to struggle with some areas of clinical engagement as they seek to move forward with PHC development at a local level. It is of note that “clinical engagement” is a term rarely used in policy related to the Strategy even though international research evidence on the development of models of integrated community and PHC services emphasises that, when embarking on significant change to the provision of PHC, it is critically important to address *both* community *and* clinical readiness, engagement and leadership (Smith and Ovenden 2007). Using terms such as “clinical engagement” *per se* may also provide a signal which shifts the rhetoric into a discourse where medical professionals feel recognised, and with which they may be more comfortable.

### **8.3 Taking forward the Strategy in order to meet Population-Health Objectives and Access Objectives**

This analysis has revealed the strength of the fees metaphor within the experience of implementing the Strategy and its capacity to get in the way of the critical work (which is desired by people across policy, management, general practice, and other communities) of developing better team-working, co-ordination, and extended service delivery at the local level. It is also evident that, to a significant extent, the fee-for-service culture persists within general practice. This is understandable, within the context of this report’s commentary on the consequences of pursuing a permissive policy approach (that is, working with those who supported the way in which the Strategy was being implemented rather than bringing to the surface and addressing the core concerns of other key stakeholders).

Some interviewees reported that the nature of the current general practice environment hindered the implementation of lower fees, because the business model remained focused on GPs seeing patients in order to maintain personal income (which was taken from the profits of the practice). Recent developments such as the Very Low Cost Access payments scheme and the Zero Fees for Under 6s scheme might be examples of alternative funding arrangements which (unintentionally) support the fee-

for-service business model, since they still focus on reducing the fees charged to individual patients and might still be seen as a per-visit subsidy. The *Evaluation's* interviews showed that practices are sometimes pursuing pragmatic solutions by developing alternative funding and employment options for GPs – such as salaried employment, an approach which might enable a population-health focus to medical practice beyond the fee-consultation “trap”. We also found instances where practices were putting in place multidisciplinary care as envisaged in the Strategy.

There are, however, risks inherent in being over-simplistic about the distinction that is often drawn (and that we have sometimes reflected in this analysis) between low fees/community-focused and higher fees/business models of general practice. The results of the *Evaluation's* interviews, whilst in many cases reinforcing such stereotypes, did also hint at shifts taking place in which lower fees/community practices are being “businesslike” in their development of new models of care and use of the capitation funding, and traditional fee-for-service providers are adapting their approach towards a greater degree of practice teamwork, preventive health initiatives, population-health needs assessment, and alignment with PHOs.

*Low fee practices have more efficient triage, they are used to dealing with high-need complex patients, they are used to working in teams and using the NGO support systems – so they just have a different approach to practice organisation. They are better at business than some of our practices that work in the old fee-for-services model and have not adjusted to the fact that you have bulk funding and you have the freedom to do things differently. Some practices have not taken the opportunities, even from a business point of view, that PHO funding offers. (DHB manager)*

A practice nurse in a large PHO described how capitation funding was leading to changes in the nature of care delivered within general practice, towards the goals set out in the Strategy.

*Practice teams have embraced capitation as was expected and required. Now that nurses have taken a greater role in the practice you will find them appropriately seeing patients in circumstances where previously doctors might have seen them, and some practices have a much broader range of health professionals and health services too. So the ground has shifted; even the range of nursing skills and services is varied, as [is] the practice population and its needs. (Practice nurse)*

What this suggests is that the fees metaphor (and the associated relationship played out in the public arena) may sometimes obscure the extent to which change towards a more population-focused approach to PHC is taking place.

## **8.4 Incrementalism and the Role of Contracts in PHC**

Beyond the “noise” of national negotiation, and beyond the difficult positions that key stakeholders sometimes appear to find themselves in, many practices and other providers appear to be willing to move forward into new agreements and arrangements such as the Very Low Cost Access payments scheme. This arguably represents an incremental move towards a more complete contracting environment between the state and general practice.

The incremental approach to introducing formal contractual arrangements is consistent with a general approach to introducing formal arrangements and to specifying roles adopted under the Strategy's reforms. This gradual approach to wide-scale change is pragmatic and constructive, to the extent that new funding and ownership models are emerging within general practice in New Zealand – as in the case of the take-up of the Very Low Cost Access payments scheme by eligible practices, and the introduction of DHB-employed GPs.

The change management literature suggests, however, that a process of partial and incremental contracting has its limitations, and that for bringing about wider-scale change there are points at which reframing of the situation is needed and debate about potential alternative funding and contracting approaches held. This is based on evidence from organisational research on the potential consequences of failing to address core concerns and grievances (e.g. Pettigrew, Ferlie and McKee 2004).

A key policy question is, therefore, how far an incremental approach to introducing formal arrangements is sustainable and acceptable as an approach to implementing the Strategy and to seeking to bring about the next phase of significant change within the PHC sector. Part of reframing the relationship between the state and general practice might be the abandoning of this incremental approach, together with the uncertainty and misunderstandings it creates (as shown in the negative consequences of the fees metaphor). An alternative is to have a fuller and more inclusive discussion about where the Strategy's implementation is headed and what this might mean in terms of future contract and funding options for general practice and, indeed, for other providers.

One of the options for future development of PHC in New Zealand, whether incremental or sudden, is a shift towards formal contractual arrangements – extending existing arrangements that make funding conditional on specific performance (including specific reductions in patient fees).

New Zealand has not, historically, had widespread or long-lasting formal contractual relationships between government organisations and GPs. This means that the Strategy was introduced into an environment where the government had no formal contractual means for meeting some of its objectives – in particular, for achieving universal low fees and for ensuring that providers received capitated funding. This lack might, however, be rational given the limitations of formal contracts in health care (Allen, Croxson, Roberts, Archibald, Taylor, and Crawshaw 2002; Robinson 2001). High transaction costs mean that formal contracts are inevitably partial, with gaps filled by informal arrangements that include information sharing and constraints on behaviour. Trust is a key informal arrangement in this type of environment – so if it is missing, as was arguably the case in New Zealand when the Strategy was introduced – a vital component of the informal institutional arrangements is also missing.

In an incomplete contracting environment, dysfunctional metaphors which reinforce conflict will have disproportionate importance. In this context, attempts to get formal agreement around fees-related issues and to introduce formal contractual arrangements may be interpreted as attempts to gain control. Ironically, attempts to impose formal contracts therefore undermine the informal relationships necessary to sustain those same formal contractual arrangements. In this context it is vitally important to find a way through grievances and to change the nature of the debate. It may also be the case that incrementally introducing formal contracts, as has happened to date, is optimal.

Formal contracts introduced with goodwill and in a co-operative environment may be an important tool in creating a boundary around the fees issue, and in undermining its metaphorical status. Dealing with fees as fees, and funding as funding, is an important step towards improving informal arrangements and relationships across the New Zealand PHC system.

## 9 CONCLUSION

Now that roll-outs of new funding for first-contact care are complete, it is generally agreed that the next phase of the Strategy's implementation requires a shift away from a focus on infrastructure and fees towards the issue of how changes to the provision of PHC can be enabled in a way that fulfils the aims of the Strategy. This means that the time has arguably come for an exploration of future options relating both to the relationship between the state and general practice and to how the capitation environment can be developed. One approach would be to present the PHC sector with a "menu" showing a range of contracting, funding and employment options.

If the "fees issue" has been a central metaphor within the implementation of the Strategy to date, the challenge facing New Zealand's PHC stakeholders in 2008 is to debate and agree what metaphor they would like to develop as an alternative. Similarly, the acceptability of partial formal contracting within PHC is an issue for consideration as the Strategy is taken forward. Our analysis of fees and funding within the Strategy is intended as a contribution to the debate about the Strategy's implementation. Fundamentally, it is intended to be an examination of what the fees issue represents and to help shape the way in which discussions about PHC funding might proceed.

Commentary on New Zealand PHC reform since 2001 has often noted the existence of parallel (or even competing) world views about the future of PHC and its organisation, and has connected these to the two sides of the relationship between the state and general practice (see, for example: Crampton, Davis and Lay-Yee 2005; Smith and Mays 2007; Gauld 2008). If the metaphor of a fault line is applied to this apparently binary situation, the question that arises is, "at what point will the earth crack apart into two islands?" This may appear to be an extreme analysis of a possible trajectory of policy implementation, but it does point to a potential future where, if the relationship encapsulated in the fees metaphor were to remain unaddressed, it could result in the parallel and separate development of two forms of PHC services in New Zealand. Arguably, painting this picture of the future is a small part of the process of bringing to the surface the issues focused within the fees metaphor and enabling a more in-depth consideration of how the Ministry, DHBs, PHOs and general practice can work together to shape an alternative, more negotiated and inclusive plan for the next phase of the Strategy's implementation.

# REFERENCE LIST

- Allen P., Croxson B., Roberts J., Archibald K., Taylor L., and Crawshaw S. (2002) "The Use Of Contracts in the Management of Infectious Disease Related Risk in the NHS Internal Market" *Health Policy* 59(3), 257-281.
- Barnett P., Smith J, and Cumming J. (2009) *The Roles and Functions of Primary Health Organisations*. Wellington: Health Services Research Centre.
- Boniface L. (2007) "Call the Doctor" *New Zealand Listener*, 208(3502) June 23-29. Available at: [http://www.listener.co.nz/issue/3502/features/9052/call\\_the\\_doctor.html](http://www.listener.co.nz/issue/3502/features/9052/call_the_doctor.html)
- Crampton P., Davis P., and Lay-Yee R. (2005) "Primary care teams: New Zealand's experience with community-governed non-profit primary care" *Health Policy* 72(2), 233-243.
- Cumming J., Raymont A., Gribben B., Horsburgh M., Kent B., McDonald, J., Mays, N. and Smith, J. (2005) *Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy: First Report*. Wellington: Health Services Research Centre.
- Davidson D. and Peck E. (2006) "Organisational development and design" in Walshe K. and Smith J. (eds) *Healthcare Management* pp342-363. Buckingham: Open University Press.
- Gauld R. (2008) "The Unintended Consequences of New Zealand's Primary Health Care Reforms" *Journal of Health Politics, Policy and Law* 33(1), 93-115.
- Gribben B. and Cumming J. (2007) *Evaluation of the Primary Health Strategy: Practice Data Analysis 2001-2005*. Wellington: Health Services Research Centre.
- Hay I. (1989) *The Caring Commodity: The Provision of Health Care in New Zealand*. Auckland: Oxford University Press.
- Health Benefits Review (1986) *Choices for Health Care: Report of the Health Benefits Review*. Wellington: Health Benefits Review.
- Iles V. and Sutherland K. (2001) *Managing Change in the NHS*. London: NCCSDO.
- Minister of Health (2001a) *The Primary Health Care Strategy*. Wellington: Ministry of Health. (<http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/7bafad2531e04d92c2569e600013d04?OpenDocument>)
- Minister of Health (2001b) "Launch of New Zealand Primary Health Care Strategy". Media release 1 February 2001. (<http://www.beehive.govt.nz/ViewDocument.aspx?DocumentID=9501>)
- Minister of Health (2007) "More support for free doc visits for under-6s". Media release 27 August 2007. (<http://www.beehive.govt.nz/release/more+support+free+doc+visits+under-6s>)

- Ministry of Health (1999) *Taking the Pulse: The 1996/97 New Zealand Health Survey*. Wellington: Ministry of Health.
- Ministry of Health (2004) *A Portrait of Health: Key Results of the 2002/03 New Zealand Health Survey*. Wellington: Ministry of Health.
- Morgan G. (1997) *Images of Organisation*. London: Sage.
- Pettigrew A., Ferlie E., and McKee L. (1992) *Shaping Strategic Change*. London: Sage.
- Pettigrew A., Ferlie E., and McKee L. (2004) "Receptive and non-receptive contexts for change" in Clarke A., Allen P., Anderson S., Black N., and Fulop N. (eds) *Studying the organisation and delivery of health services: A Reader* pp249-259. London and New York: Routledge.
- Raymont A. (2004) *Cost Barriers to Health Care: Provisional Analysis from the New Zealand Health Survey 2002/03*. Wellington: Ministry of Health.
- Raymont A. and Cumming J. (2009) *Status and Activities of General Medical Practices*. Wellington: Health Services Research Centre.
- Robinson J.C. (2001) Theory and practice in the design of physician payment incentives. *The Milbank Quarterly* 79(2), 149-177.
- Sibthorpe B., Glasgow N., and Longstaff D. (2004) *Complex Adaptive Systems: A Different Way of Thinking about Health Care Systems*. Canberra: Australian Primary Care Research Institute, Australian National University (ANU).  
[http://www.anu.edu.au/aphcri/Publications/Background\\_paper\\_stream1.pdf](http://www.anu.edu.au/aphcri/Publications/Background_paper_stream1.pdf)
- Smith J.A. and Mays N. (2007) "Primary care organisations in New Zealand and England: tipping the balance of the health system in favour of primary care?" *International Journal of Health Planning and Management* 22(1), 3-19.
- Smith J.A. and Ovenden C. (2007) *Developing integrated primary and community health services: what can we learn from the research evidence?* Counties Manukau District Health Board and the Health Services Research Centre, Victoria University of Wellington.
- Weick K. E. (1995) *Sensemaking in organisations*. London: Sage.